sultant status. The irony of the situation is that we hear repeatedly that there is lack of trained doctors suitable for consultant appointments and that no more consultant posts should be advertised for the time being. This implies that none of the medical assistants in accident and emergency currently in post is considered suitable for a consultant appointment. The question is who took that decision. I have a strong suspicion that this policy is propagated by consultants in other specialties who are anxious to keep control of the accident and emergency departments. I happen to know personally a number of medical assistants who are excellent doctors, and who in spite of the restrictions which their status imposes on them have been doing a marvellous job in many parts of this country.

I think it is time the profession shows more concern for the treatment which a group of our colleagues are suffering and whose status makes it difficult for them to argue their case. This should be a matter of concern for all of us. I am aware of the fact that time and time again articles have been written in the *BMA News Review* and other publications, but so far nothing constructive has been done to solve this problem fairly, which I am sure is causing a lot of anxiety to a number of doctors and their families.

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Isolated communities and their doctors

SIR,—Ever since the Rural Practice Fund replaced the old milage scheme in 1963 there has been progressive loss of general practitioners serving isolated communities. The Rural Practice Fund was intended to benefit rural doctors, but evidence has amassed to show that the real benefit was to doctors practising in small towns serving country areas. Thus today it is not uncommon for patients living in country areas to have to travel 10 miles (16 km) or more to country town group practices.

The Rural Practice Fund was specifically designed "to compensate the doctor working in a scattered practice for his proportionately greater expenses and few patients." But enlarging the qualifying radius disproportionately increased the area (πr^2) in which units could not be claimed. There are few direct roads in the country and to visit patients living three miles apart often means a journey of ten miles. A single-handed doctor has to serve the whole area but semirural partnerships are able to divide up the area, with consequent improvement in efficiency. In fairness, we believe, a two-man partnership should have a four-mile radius without entitlement to any milage units, a three-man partnership a five-mile radius, and so on. Fewer units to distribute would mean more money for each unit.

There can be no doubt that the application of the rule for fringe-urban practices created an injustice. It subsidised partnerships to invade the countryside and encouraged the absorption of practices which had become non-viable because of the rule. The situation continues today, though there are now few isolated practices left to be absorbed.

The problems of the single-handed isolated country doctor were nicely described in 1975 by the chairman of the Rural Practices Com-

mittee. Commenting on the trend to partnerships in the country areas he said, "Most of the single-handed [village] doctors left are unable to join partnerships for geographical reasons and so have difficulty in making rota arrangements. Locums are increasingly hard to find and in any case are expensive. So, often the single-handed doctor has to soldier on with inadequate off-duty, little or no holiday, and insufficient time for postgraduate study." A survey of isolated practices in 1977 confirmed these views, and the present position has been clearly described by Scott.³

Surely what is required is an independent inquiry into the distribution of the Rural Practice Fund. Since its inception in 1963 rural doctors have been worse off than they were before, relatively, and a good case can be made for saying that it has adversely affected rural communities. Indeed, recent public discussion has pointed to the value of the village doctor along with the post office and school in maintaining the communal life of small villages. If there is to be a new charter for general practice then the wrongs which have existed since 1963 must be corrected. The New Charter Working Party has suggested many sensible improvements for general practice as a whole. We welcome the recommendations concerning special locum arrangements for isolated practices and a new look at the "linking of some practices in rural areas,"⁴ but consider that these alone cannot redress the balance.

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¹ *British Medical Journal*, 1963, 1, 13.

² Wilson, M A, *British Medical Journal*, 1975, 1, 108.

³ Scott, G, *World Medicine*, 1979, 14, (9), 42.

⁴ British Medical Association, *Report of New Charter Working Group*. London, BMA, 1979.

The new consultant contract

SIR,—The new consultant contract embodies the new concept that private practice will be open to all practitioners. If the maximum schedule of 13 sessions were allocated then the practitioner would be able to carry out private practice. Only when 14 or 15 NHDs are worked would private practice be precluded. No doubt the CCHMS envisaged that most practitioners would opt for 11-13 NHDs so that further remuneration from the private sector would supplement the diminishing returns of the NHS salary. This seemed a fair compromise as the decision to opt in or out of private medicine would go and the division between full-timers and part-timers be removed.

The workings of the Health Services Board regarding the new contract has escaped many of those writing to the *BMJ*. Consultants in some specialties—for example, radiology, radiotherapy, and pathology—require facilities available only in NHS hospitals. If during the time when statistics were collected by the Health Services Board no consultant in these specialties was part-time the facilities would

not appear to have been used for private practice and would be revoked.

Revocation of facilities for use of private patients virtually precludes private practice in those specialties requiring NHS equipment. A keystone of the new contract has now been removed by the Health Services Board. The division would still exist between the specialties which have a revocation order against them and those that do not. The holders of the old contract would not be vulnerable but new appointees would be virtually appointed as full-timers (on negotiated NHDs) as they would have no access to NHS equipment necessary for their private practice. I feel that this seriously erodes a fundamental concept of the new contract. A further ballot is now necessary after pricing so that remuneration can be agreed in the wake of the Health Services Board revocation proposals.

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SIR,—Further to the letters of Dr D E B Powell (24 March, p 825) and Mr Russell Hopkins (14 April, p 1022) concerning recall fees, I agree with Mr Hopkins that it has been a scandal since the advent of the NHS that the surgical specialties have been imposed on in this way. However, the statement that "Pathologists make several thousand extra pounds a year for their medicolegal work carried out during normal working hours" requires qualification.

Some of my colleagues do in fact get away with this and good luck to them. However, there are others, particularly those attached to the Home Office, whose peculiarly skilled and difficult work takes place mainly out of working hours but who, none the less, feel it only right and proper to give up sessions if undertaking this or private work. Needless to say, many of these unhappy individuals find that the unique responsibilities of their appointment de facto bar them from NHS awards, while their natural—indeed essential—wide interests expose them to remorseless and relentless pursuit by the demarcation squads of the Royal Union of "Pathologists."

Compared with our whole-time colleagues, we are indeed amateurs in at least one sense of the word.

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Peripheral hospitals and the new career structure

SIR,—I take Mr R T Booth's point (13 January, p 128) about the importance of equating service and training posts, and so far as the Guy's regional obstetric and gynaecology programme is concerned I do not feel the balance is too uneven. If one concedes that each district should have a maternity unit within the complex of the district general hospital, there are in the South-east Thames Region three teaching hospitals and 13 district hospitals, making a ratio of 1:4.3. The Guy's programme—contrived, I may say, with the full participation of my regional colleagues—involves Guy's and four regional hospitals